U.S. Department of Transportation
United States Coast Guard

Commandant
U.S. Coast Guard

2100 2nd Street S.W.
Washington, DC 20593-0001
Staff Symbol: G-WKH-1
Phone: (202) 267-0767

COMDTINST M6000
March 27, 2002
CANCELLED:
March 27, 2003

COMMANDANT NOTICE 6000

Subj: CH-17 TO MEDICAL MANUAL, COMDTINST M6000.1B

1. PURPOSE. This Notice publishes revisions to Medical Manual, COMDTINST M6000.1B. Intended user of this directive are all Coast Guard Units that maintain Medical Manuals.

2. ACTION. Area and district commanders, commanders of maintenance and logistics commands, commanding officers of Headquarters units, Assistant Commandants for directorates, Chief Counsel and special staff offices at Headquarters shall ensure compliance with the provisions of this Notice.

3. DIRECTIVES AFFECTED. Medical Manual, COMDTINST M6000.1B.

4. SUMMARY. Newly revised material and editorial changes are denoted by a line on the outside of the page. Enclosure (1) summarizes the substantial changes throughout the Manual provided as enclosure (2).

5. PROCEDURES. No paper distribution will be made of this Manual. Official distribution will be via the Coast Guard Directives System CD-ROM and the Department of Transportation Website http://isddc.dot.gov/. An electronic version will also be made available via the Commandant (G-WK) Publications and Directives website (see # 6, below).

   a. Remove and insert the following pages

Remove	Insert
Chapter 1 CH-16 pg 39-40	Chapter 1 CH-17 pg 39-40
Chapter 2 CH-16 pg 9-10	Chapter 2 CH-17 pg 9-10
Chapter 3 CH-16	Chapter 3 CH-17
Chapter 4 CH-16	Chapter 4 CH-17
Chapter 7 CH-15	Chapter 7 CH-17
Chapter 8 CH-15 pg 13-14	Chapter 8 CH-17 pg 13-14

DISTRIBUTION – SDL No. 139

	a	b	c	d	e	f	g	h	i	j	k	l	m	n	o	p	q	r	s	t	u	v	w	x	y	z
A	1	1	1		2	2	2	1					1		1						3					
B		8	10*		12	5	2	11	2	2	0	6	1	3		2	2	60				1				
C	1*	1*		*	1				*		*2	*	1	1						1		1	1			
D				3			1			*		*	1	1												
E																										
F																	1	1	1							
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NON-STANDARD DISTRIBUTION:

Chapter 10 CH-15 pg 17-18	Chapter 10 CH-17 pg 17-18
Chapter 11 CH-15	Chapter 11 CH-17
Chapter 12 CH-16	Chapter 12 CH-17
Chapter 13 CH-13 pg i-iii	Chapter 13 CH-17 pg i-iii
Chapter 13 CH-13 pg 11-14	Chapter 13 CH-17 pg 11-14
Chapter 13 CH-13 pg 27-28	Chapter 13 CH-17 pg 27-28
Chapter 13 CH-13 pg 97-104	Chapter 13 CH-17 pg 97-104
	Chapter 14 CH-17

6. FORMS AVAILABILITY. All forms listed in this Manual with the exception noted in this paragraph are available from stock points listed in the Catalog of Forms, COMDTINST 5213.6. Local reproduction authorized for the Modified Physical Examination. Availability of DD-2808 Report of Medical Examination and DD-2807-1 Report of Medical History is only by .pdf format, a web link is provided on the Pubs and Directives web page. Some forms referenced in this Manual are also available on SWSIII Jet Form Filler. Web links to forms in .pdf format have been provided on the Pubs and Directives page; http://www.uscg.mil/hq/g-w/g-wk/g-wkh/g-wkh-1/Pubs/Pubs.Direct.htm.

JOYCE M. JOHNSON
Director of Health and Safety

Encl (1) Summary of substantial changes
(2) CH-17 to Medical Manual, COMDTINST M6000.1B

CH-17 to Medical Manual, COMDTINST M6000.1B

Chapter 1	
Chapter 1-B-21	Adds new sub-section 1-B-21, and provides guidance for (Volunteers).
Chapter 2	
Chapter 2-A-6-(4)	Provides clarification of Elective Health Care and fitness for duty.
Chapter 3	
Chapter 3-A-7-d	Provides new guidelines for Overseas Transfer, Sea Duty Deployment and Port Security Units.
Figure 3-A-1	Revised Modified Physical Exam Form. Form authorized for local reproduction.
Chapter 3-C	Section revised to match sequence of the new DD-2808 (Report of Medical Exam) and 2807-1 (Report of Medical History). No content was changed.
Chapter 3-B-1&2	Revised paragraphs to reflect new physical exam forms.
Chapter 3-C-21-b(9)(b)4	Revised paragraph to read HIV testing is every 5 years.
Chapter 3-C-21-b(9)(b)8	Added new sub-paragraph to identify tuberculin reactors.
Chapter 3-C-21-b(i)	Removed reference to Reportable Disease Data Base (RDDB) no longer used.
Chapter 3-C-20-b(9)(e)	Revised paragraph to provide narrative summary to be obtained by the referring medical officer.
Chapter 3-C-22.j(1)(a)(5)	Revised paragraph to reflect update to the process of color perception testing.
Chapter 3-F-2	Provides new guidance for the List of Disqualifying Conditions and Defects.
Chapter 3-F-22	Revised definition for Human Immunodeficiency Virus (HIV)
Chapter 3 –G-4-d.	Added required self-balancing test for aviation physicals.
	Replaced all references to the new DD-2808 (Report of Medical Examination) and DD-2807-1 (Report of Medical History)
Chapter 3	Chapter layout re-formatted.
Chapter 4	
Chapter 4-A-6-b	Provides guidance for the transfer of Active Duty Health records.
Chapter 4-A-2(5)(g)	Updated section to provide placement of the audiogram microprocessor test strip in the Health Record.
Chapter 4-B-6	Revised section to delete form SF-88 (Report of Medical Examination) and replaced form with new form DD-2808 (Report of Medical Examination)
Chapter 4-B-7	Revised section to delete form SF-93 (Report of Medical History) and replaced form with DD-2807-1 (Report of Medical History).
Chapter 4-D-8-b	Provides guidance for the transfer of Dependant Health Records
Chapter 4-B-3-b(2)	Revised section to include NKDA (no known allergies) in section 1-a of the DD-2766 (Adult Preventive and Chronic Care Flowsheet)
Chapter 4-B-9&10	Revised section to make the DD-2215 (Reference audiogram and DD-2216 (Hearing Conservation Data Sheet and optional form.
Chapter 4-B-11	Updated section to include placement of audiogram results into the health record.
Chapter 4-	Reformatted Chapter 4 adding (Enclosure (1) Medical/Dental Record

Enclosure (1)	Forms(.jpegs)). Developed this new enclosure to prevent having to download forms, when new text is added to Chapter 4.
Chapter 7	
Chapter 7-B-2-b(3)	Revised paragraph to send a Coast Guard intranet e-mail message Disease Alert report.
Figure 7-B-1	Revised List of Reportable Conditions.
Chapter 7-B-3-b	Revised subsection (1) to submit Initial Report to MLC(k), copy to WKH-1.
Figure7-B-3	Revised line 5 to read: Laboratory test done, if any, and results.
Chapter 7-C-4-f	Revised paragraph for the administration of vaccines.
	Re-formatted Chapter 7 page numbers have changed.
Chapter 8	
Chapter 8-E-3.b(2)	Removed Optical Fabrication Laboratory form table.
Chapter 10	
Chapter 10-B-2-b(1)(a)	Revised paragraph to reduce letters of designation for the Controlled Substance Audit Board.
Chapter11	
Chapter 11-C-3-a(1)	Removed reference to CG-5534 (Non-Fed Med form) form removed with CH-16
Chapter11-C-5-b(2)	Removed reference to CG-5534 (Non Fed Med form) form removed with CH-16
	Chapter reviewed for accuracy and re-formatted.
Chapter12	
	All references to the SF-88 Medical Examination & SF-93 Medical History have been removed. These forms are replaced with the DD-2808 Report of Medical Examination and DD-2807-1 Report of Medical History
Chapter12-A-2-c(3)	Revised text to include new (Note) section to cover new OMSEP enrollees.
Chapter 12-C-3-d(2)b.c.d.	Revised text to provide new guidelines for acute exposure examination.
Figure12-C-2	Revised text to include: blood or breath benzene level (optional-if available)
Chapter12-C-7-d-(5)	Revised paragraph to clarify guidance for audiogram STS.
Chapter 12-C-9-d	Paragraph revised to clarify Examination protocol.
	Chapter12 re-issued, page numbers have changed.
Chapter13	
Chapter –13-B-4-f	Revised section to provide guidelines for: Proof of current competences.
Chapter 13-B-5-b(4)	Revised section to submit documentation of CME credentials every other year.
Chapter 3-G-1-c(2)	Revised paragraph to increase “other element” from 60% to 80%.
Chapter 13-M-2-c(4)	Deleted Practicum Guide for HS’s
Chapter 14	
Introducing new Chapter 14 - Medical Information System (MIS) Plan	

patient transport via gurney or wheelchair within the clinic; assessing and properly recording temperature, respiratory rate, heart rate, and blood pressure; acting as a chaperone during exams or treatment; assisting in specialty areas, i.e., laboratory (with appropriate additional training and supervision); answering telephones, filing and other clerical duties; cleaning and wrapping instruments.

b. Supervision. Supervision of Red Cross volunteers is the responsibility of the Clinic Administrator and may be delegated.

c. Orientation. Each volunteer must have an initial orientation to the clinic documented. Orientation shall include at least the following topics:

(5) Fire Safety,

(6) Emergency procedures (bomb threats, mass casualty, power outages, hurricanes/tornadoes),

(7) Universal precautions and infection control,

(8) Proper handling of telephone emergency calls,

(9) Phone etiquette, paging, proper message taking,

(10) Patient Bill of Rights and Responsibilities, to include confidentiality, and chaperone duties in accordance with Chapter 2-J-3-b of this Manual.

21. Volunteers

a. Volunteer health care workers (HCW) who are not health care providers and who are members of the U. S. Public Health Service (USPHS), Department of Defense (DOD) or Coast Guard Auxiliary (AUX) shall work under the supervision of clinic staff and will provide support services that include but are not limited to: patient transport via gurney or wheelchair within the clinic, assessing and recording vital signs, acting as a chaperone during examination or treatment, clerical duties such as answering telephone or filing, cleaning and wrapping instruments, etc.

b. Health care providers who are members of the USPHS or DOD who volunteer to work in Coast Guard clinics for up to fourteen days per year will not be required to apply to G-WK for clinical privileges.

(1) Volunteer providers in this category will submit a copy of a current active state license, copy of current clinical privileges and a current CPR card to the local clinic when they report in. They will also complete a request for clinical privileges appropriate to their category and submit to the local SMO/SDO. Volunteer providers can also submit a Credentials Transfer Brief in lieu of their license and CPR card.

(2) The SMO/SDO will evaluate the clinical privileges requested and by signing the request will authorize the provider to perform those health care services.

c. Health care providers who are members of the USPHS or DOD who volunteer to work in Coast Guard clinics for more than fourteen days per year will be required to apply for clinical privileges from G-WK as described in Chapter 13-B, and C of this Manual.

d. Health care providers who are members of the AUX will be required to apply for clinical privileges from G-WK as described in Chapter 13-B, and C of this Manual.

e. Volunteer providers will work under the direct or indirect supervision of Coast Guard clinic providers.

f. Each volunteer must have an initial orientation to clinic standard operating procedures which must be documented and must include at the minimum:

   (1) Fire safety

   (2) Emergency procedures (e.g., bomb threats, mass casualty, power outages, hurricanes/tornadoes)

   (3) Universal precautions and infection control

   (4) Proper management of telephone calls, emergency calls

   (5) Telephone etiquette, paging, taking messages

   (6) Patient sensitivity and confidentiality

(2) Coast Guard health care facilities are not required to provide such information under the law. Clinics may elect to provide standardized information to patients on request. Information given out shall conform to the implementing laws of the state in which the clinic is located. Clinics providing such information shall notify patients of its availability either by posted notice or via patient handout materials.

(3) Clinic staff members usually do not have the required training and experience to advise patients on the legal issues concerning creation of advance directives. Patients shall be referred to the appropriate source of legal support, e.g., command or district legal officers.

(4) Clinic staff members, where allowed by state law, may serve as witnesses to advance directive signatures.

(5) Advance directive documents shall be held by the member and/or the member's next of kin. Advance directive documents shall not be filed in the member's health record since health records are not universally available 24 hours a day, seven days a week, for reference by a treating hospital.

5. Elective Surgery for Pre-Existing Defects.

a. General. In many medical/dental procedures undertaken to correct defects that existed prior to entrance (EPTE) into the Service, the likelihood of return to full duty is questionable. In addition, such cases have often resulted in long periods of convalescence with subsequent periods of limited duty, outpatient care, and observation which render the Government liable for benefits by reason of aggravation of these defects.

b. Criteria. The following conditions must be met before attempting surgical correction of an EPTE defect.

(1) It interferes with the member's ability to perform duty.

(2) The procedure being considered is an accepted one, carries a minimal risk to life, and is not likely to result in complications.

(3) There should be a 90 percent chance that the procedure will correct the defect and restore the member to full duty within a reasonable time (three months) without residual disability. If the defect does not meet the above conditions and the member is, in fact, unfit to perform the duties of grade or rate, action shall be taken to separate the member from the Service.

c. Discussion. Whether elective medical/dental care should be undertaken in any particular case is a command decision which should be decided using the above guidelines. In questionable cases, the member may be referred to a medical board for final decision prior to undertaking elective treatment for an EPTE defect.

6. Elective Health Care.

   a. Medical/Dental treatment not required to maintain the member's fitness for duty is elective in nature and is not authorized for payment by the Coast Guard. If the member's condition does not interfere with their ability to perform duty, the treatment shall be considered elective.

      (1) Elective care may be obtained, if available, from USMTF's.

      (2) If obtained from nonfederal providers, payment is the member's responsibility. In addition, the member is financially responsible for any care arising from complications that require additional treatment, even if it is non-elective.

      (3) Because complications could lead to subsequent action by the Physical Disability Evaluation System (PDES), and to protect the interests of both the service member and the Coast Guard, the member's health record must contain a SF-600 entry detailing:

         (a) the personnel action to be taken by the command regarding the granting of absence;

         (b) that the service member was counseled regarding the provisions contained herein and other applicable directives. Counseling will be provided at the local Coast Guard primary care facility, or if there is no near by Coast Guard primary care facility, then the cognizant MLC (k) via phone. SF-600 will be faxed to the cognizant MLC (k) for appropriate entries, then faxed or mailed back to the unit for incorporation into the member's health record.

         (c) that the service member must obtain copies of all treatment records from the provider for inclusion into the Coast Guard health record, including initial evaluation, treatment plan, progress notes, and follow-up care.

      (4) Members shall understand that once they have received an elective treatment or procedure, they may be adversely effected for present or future assignments or specialized duty. For example, Laser In-situ Keratomileusis (LASIK) is disqualifying for divers, aviation personnel, and landing signal officers (LSO).

7. Other Health Insurance (OHI)

   a. General. In some situations a member may desire to utilize their spouses' health insurance (OHI) to obtain health care outside of the Military Health Care System. Whether elective health care or all other areas of health care, this decision has an impact on the command and possibly on a member's access to the Physical Disability Evaluation System (PDES).

   b. Criteria. The following conditions must be met before utilizing a spouse's health insurance or OHI,

visual acuity check is required and indicates the current prescription is inadequate, and obtain a refraction.

a. Available Eyewear and Standard Eyewear Sources of Supply.

(1) These types of eyewear are available:

Type of Correction	Cellulose acetate frame	
	Glass Lens	**Plastic Lens**
Single Vision, white [1]	X	X
Single Vision, tinted [1, 2]	X	X
Bifocal, 25mm segment, white [1]	X	X
Bifocal, 25mm segment, tinted [1, 2]	X	X
Trifocal, white	X	
Cataract Aspheric		X
Trifocal, white and tinted [1, 2]		X

(1) Eyewear provided in FG-58 (Flight Goggle) mounting for authorized personnel

(2) Only N-15 and N-32 tints authorized

(2) Process all requests for standard prescription eyewear through the below military optical laboratory; this is the only optical laboratory from which Coast Guard units are authorized to order standard prescription eyewear.

Naval Ophthalmic Support and Training Activity
Yorktown, VA 23691-5071

(a) The Coast Guard pays only for glasses ordered and processed for Coast Guard active duty or retired personnel; therefore, it is extremely important to properly complete the DD-771 service identification block to indicate the patient's service affiliation.

(3) Procurement Procedures. Order all prescription eyewear using DD-771, Eyewear Prescription. It is extremely important to accurately complete the prescription form. If the prescription is wrong, the patient is inconvenienced; the Coast Guard is required to pay for eyewear even if it cannot be used; and the supply activity will reject an improperly prepared prescription, resulting in delay. Use these guidelines to prepare DD-771. See Section 4-B for more detailed instructions.

(a) Use a separate DD-771 for each type of eyewear.

(b) If no health services personnel are available at the unit, send the prescription obtained from the health record or local civilian source to the health record custodian to prepare and submit the DD-771.

(c) Submit all three DD-771 copies to the approving authority or supply activity; disregard the distribution instructions. Remove all carbon sheets before submission. File a photocopy of the DD-771 in the member's health record.

(d) TRACEN Cape May shall send recruits' eyewear prescriptions separately and mark the envelope, "RECRUIT—PLEASE EXPEDITE".

(e) Report delays longer than eight weeks in receiving eyeglasses to the appropriate MLC (k).

(4) Health Record Entries. Record on a separate DD-771 the current prescription, including frame measurements and all other data necessary to reorder eyewear, for each individual requiring eyeglasses.

4. Aviation Prescription Lenses. These personnel are authorized two pair of clear aviation spectacles (FG-58) and one pair of tinted spectacles (N-15) in matte chrome only:

a. Aviators Engaged in Actual Flight Operations. Aviation spectacles may be ordered for distant vision correction , or for distant vision and near vision correction (bifocal lenses). Those aviation personnel engaged in flight operation who desire near vision only correction in aviation frames must order bifocal lenses containing plano top portion and the near vision correction on the bottom. Spectacles containing only near vision correction are not authorized in aviation frames. This type correction will only be order in cellulose acetate frames.

b. Landing Signal Officers (LSO).

c. Coast Guard Ceremonial Honor Guard personnel.

d. Small Boat Crew required to wear a helmet while performing their assigned duties.

5. Contact Lenses. Contact lenses are issued only to active duty personnel for postocular surgical difficulties or to enable a member to overcome a handicapping disease or impairment. MLC (k) will not approve contact lenses solely for cosmetic reasons.

Section B- Controlled Substances

1. General.

   a. Controlled substances, as used here, are defined as:

      (1) drugs or chemicals in DEA Schedules I-V: (for example, the manufacturers label for Acetaminophen with Codeine #3(30 mg.) carries the DEA symbol for Schedule III (C-III) and will be treated as a Schedule III by Coast Guard units.)

      (2) precious metals;

      (3) ethyl alcohol (excluding denatured);

      (4) other drugs or materials the local commanding officer or Pharmacy and Therapeutics Committee determine to have significant abuse potential.

   b. Coast Guard authorized uses for controlled substances are:

      (1) medicinal purposes;

      (2) retention as evidence in legal or disciplinary actions; or

      (3) other uses CG Regulations specifically authorize.

   c. Quantity Definitions. Due to the potential for abuse and associated audits required, Coast Guard units should strive to minimize the quantities of controlled substances used. Two types of quantities are recognized for controlled substances:

      (1) Working Stock. Working stock is defined as a 30 day supply (under routine conditions) of a controlled substance or limited amounts of emergency drug as might be required. For smaller facilities, with limited quantities of controlled substances, working stock may surpass the 30 day limit when quantities are less than 1000 dosage units (tablets, capsules, etc.). It is also acceptable for partial containers to temporarily surpass this 1000 dosage unit limit.

      (2) Bulk Stock. Bulk stock is defined as a larger quantity beyond the normal working stock quantity. Bulk stock should primarily be sealed in sealed manufacturer's containers.

2. Custody and Controlled Substance Audits.

   a. Controlled Substance Custodian (CSC).

      (1) Pharmacy officers, when assigned, shall be appointed in writing as the CSC by the commanding officer.

      (2) In the absence of a pharmacy officer, COs shall designate the clinic administrator as CSC.

      (3) Medical and dental officers may serve as alternate CSCs.

      (4) Temporarily assigned personnel shall not serve as CSCs or alternates.

      (5) Under Coast Guard Regulations, COMDTINST M5000.3A, Chapter 6-2-3-A.(6), the Executive Officer is directly responsible for medical matters if a

medical officer is not assigned. For sickbays, the CO shall designate a commissioned officer as the CSC.

(6) CSCs may permit Health Services Technicians to assume custody of a "working stock" quantity of controlled substances.

(7) An audit of all controlled substances (working and bulk stock) is required when the CSC is changed. The results of this inventory shall be filled in the command's permanent file and in the Health Services Log. All keys should be transferred and/or combination locks changed at the time of this inventory.

b. Unit Controlled Substance Audits.

(1) Controlled Substance Audit Boards (CSAB). Each unit procuring, storing, or dispensing controlled substances shall have a CSAB.

(a) Membership: The CSAB shall consist of two or more disinterested officers or if unavailable, two or more disinterested senior petty officers (E-6 or above). Designated in writing by the Commanding Officer. CSAB letters of designation will remain in effect until the members are relieved in writing or detached from the command. In no case may the controlled substance custodian be a member of the CSAB.

(b) The CSAB shall conduct monthly audits of controlled substances at clinics (quarterly at ashore or afloat sickbays) and submit its report to the commanding officer within 5 working days after its audit. Commands shall maintain these reports for three years after which they may be destroyed.

(c) Monthly CSABs shall audit all working and bulk stock of C-II through C-V controlled substances, precious metals, ethyl alcohol, and drugs or other items locally designated as controlled substances due to abuse potential and report all quantities on CG-5353, Monthly Report for Narcotics and Other Controlled Drugs.

(d) During monthly audits, CSABs shall inspect controlled substances for expiration, deterioration, and inadequate or improper labeling. Expired products or those with other discrepancies shall be removed for disposal.

(e) The CSAB shall count required controlled substances; review a representative random sample of prescriptions, receipts, and issue documents; and report the results on Monthly Report for Narcotics and Other Controlled Drugs, CG-5353. For sealed containers, a bottle count is sufficient; for open containers an exact count is required. For open liquid containers, an estimate other than an exact volume measurement is adequate. CSABs may use tamper-proof seals on open containers to avoid future counting of partial quantities.

CHAPTER 13

QUALITY ASSURANCE

Section N - PATIENT AFFAIRS PROGRAM 102

d. Copies of state licenses for all states in which the practitioner is licensed (active or inactive), current renewal certificates, and Educational Commission for Foreign Medical Graduates (ECFMG) certification if the practitioner graduated from a medical school not in the Continental U. S., Hawaii, Alaska, or from a medical school not accredited by the American Association Liaison Committee on Medical Education in Puerto Rico. The practitioner must attach a statement of explanation for lapsed state licenses or those subject to disciplinary action. The primary source must verify all licenses or renewal certificates.

e. Copies of specialty board and fellowship certificates with primary source verification of these documents.

f. Proof of current (within one year) competence, i.e., two letters of reference for initial appointment and a description of recent clinical privileges held (practitioner's supervisor must note concurrence with and approval of privilege performance).

(1) The official reviewing letters of reference is authorized to contact the author of the letters to verify authorship and authenticity of letters. The official is also authorized to request a second letter of reference from an author when the first letter is deemed unclear. The official reviewing a letter of reference is authorized to contact the author via telephone in cases in which the author declines to respond in writing. In such cases, the official will document in a telephone log the site, date, time, identity of call participants and a detailed description of the conversation.

g. A statement explaining any involvement in malpractice cases and claims, including a brief review of the facts about the practitioner's involvement.

h. A statement about any hospitals', licensing boards', or other agencies' disciplinary action.

i. A copy of current certification in Cardiopulmonary Resuscitation from the American Heart Association or American Red Cross.

j. Copies of all current and prior Drug Enforcement Agency (DEA) registration, as appropriate.

k. National Practitioner Data Bank (NPDB) query.

5. Documentation.

a. Documents will be placed into a U. S. Coast Guard Training Record (CG-5285) folder. Commandant (G-WKH-2) will maintain files in a locked cabinet. PCFs and their contents are Class III (maximum security) records and protected from disclosure under the Privacy Act. Do not release documents in the PCF to any other individual or entity unless the provider has given express written permission.

b. Place documents in the six-section folder are as follows:

(1) Section One: Coast Guard clinical privilege documents.

(2) Section Two: Reference letters.

(3) Section Three: Adverse actions, malpractice documents, proof of malpractice coverage, statements about adverse information or malpractice claims.

(4) Section Four: Copies of CPR certification cards, continuing education certificates (CME), other military or civilian courses other than initial qualifying degree.

(a) By 31 December **every other year**, each provider shall submit a summary of CME completed during the **prior 2 years** to Commandant (G-WKH-2).

(b) The CME summary will be in the form of a list in tabular format and will include the name of the course, date taken, sponsoring organization and CME earned.

(c) Providers who are members of the professional organizations that maintain transcripts can submit a transcript in lieu of a summary of CME.

(5) Section Five: JCAHO-accredited hospital letter on admitting privileges, privileges granted by other or previous institutions, curriculum vitae.

(6) Section Six: Copies of license(s), diploma(s) or degree certificates, ECFMG certificate (if applicable), Internship certificate, Residency Certificate, Fellowship documents, and Board Certification. Primary sources must verify all documents in Section Six.

c. See Figure 13-B-1 for a list of required documents by provider category.

6. Verification.

a. To verify education, training, licensure or registration, certification, ECFMG and board certification, obtain either an original letter from the educational institution or certifying body attesting to successful completion of specialty training, or verify by telephone call between the Coast Guard representative and educational institution or specialty board. Record telephone verification on the document itself and on official letterhead signed and dated by the person making the call. Place all verification documents with their source documents in PCF Section Six.

b. Commandant (G-WKH) will verify uniformed services persons before appointment.

c. Before selection of Civil Service and contract providers, there will be a verification of education, training, licensure, experience, certification or registration, and current competence.

d. To verify experience and current competence requires at least two recommendation letters from appropriate sources as listed below. Commandant (G-WKH-2) or the appropriate MLC shall receive direct letters from the person providing the reference. Verify descriptions of recent clinical privileges as above.

(1) A letter either from the hospital chief of staff, clinic administrator, professional head, or department head if the individual has professional or clinical privileges or is associated with a hospital or clinic; or

(2) A letter from the director or a faculty member of the individual's training program if he or she has been in a training program in the previous two years; or

(3) A letter from a practitioner in the appointee's discipline who is in a position to evaluate the appointee's peer and a professional association or society association (mandatory if the appointee is self-employed).

7. Contract Provider Credentials Review.

a. All contract providers who perform any part of their work in a Coast Guard health care facility will submit credentials documents to the appropriate MLC per Paragraph 13.B.6. above and MLC SOPs.

b. The contracting officer will verify documents

c. At the contracting officer's request, MLC (K) will perform a technical review of the providers' credentials.

8. Reverification.

a. These credentials are renewable and will be primary source on renewal: License, PA certification, Board certification, and contract providers' malpractice coverage. Reverify contract providers' credentials at contract renewal.

b. Reverify these credentials by original letter or telephone contact The person making the call will record telephone contact on the document and by a separate, signed memorandum.

9. National Practitioner Data Bank.

c. Commandant (G-WK) possesses sole authority to report to the National Practitioner Data Bank. Commandant (G-WKH-2) is designated as the appropriate entity for National Practitioner Data Bank queries. Coordinate all queries for patient care providers through this branch.

d. A reply from the NPDB is not required before the practitioner begins providing services. However, any provider whose credential verification is not fully completed will be considered to have a conditional appointment until all credentials are verified as required.

FIGURE 13-B-1

REQUIRED CREDENTIALS BY PROVIDER CATEGORY

	A	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**	**J**	**K**
Physicians	X	X	X	X	X	X	X	X	X	X	X
General Practice Physicians*	X	X	X	X		X	X	X	X	X	X
Dentists	X	X	X	X			X	X	X	X	X
Physician Assistants	X	X	X	X			X	X	X		X
Nurse Practitioners	X	X	X	X			X	X	X		X
Optometrists	X	X		X			X	X	X		X
Physical Therapists	X	X	X	X			X	X	X		X
Dental Hygienists	X	X		X			X	X	X		X

A. Current curriculum vitae

B. Copies of qualifying educational degrees

C. Copies of required postgraduate training certificates for the area of work; for example, internship, residency, fellowship, nurse practitioner or physician assistant schooling

D. Copies of state license(s)

E. Copies of specialty board certification and fellowship certificates

F. Proof of current competence, recent clinical privileges

G. Proof of malpractice coverage (contractors only)

H. Statement explaining malpractice claims, other adverse actions

I. CPR certification

J. DEA certification

K. NPDB query

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* General Practitioners. Physicians who have completed one year of Graduate Medical Education (Internship) and have not completed a full residency in a medical specialty.

Section G - Coast Guard Clinic Certification and Accreditation

1. Clinic Certification Program.

   a. Background. Commandant (G-WK) must certify all Coast Guard clinics with assigned medical and dental officers to provide health services. Clinic certification is based on complying with standards set forth in the Medical Manual, COMDTINST M6000.1 (series), and MLC Quality Assurance (QA) Checklists. Commandant (G-WK) certifies facilities based on the results of Quality Assurance site surveys conducted by Maintenance and Logistics Commands.

   b. Responsibility.

      (1) Unit. The unit commanding officer is responsible for ensuring the command's health care facility complies with standards set forth in the Coast Guard Medical Manual and MLC QA Checklists and for meeting the minimum requirements set forth for clinic certification.

      (2) Maintenance and Logistics Command. Chief, Health and Safety Division is responsible for developing and coordinating QA Checklists and periodically conducting Quality Assurance Site Surveys at facilities in their area of responsibility. These surveys will assess compliance with existing directives and recommend the facility's certification status based on survey results.

      (3) Headquarters. Chief, Office of Health and Safety coordinates and directs the certification program, issues certificates to certified clinics, adjudicates appeals, and promulgates appropriate standards governing Coast Guard providers' delivery of health care and policies on managing and operating Coast Guard health care facilities.

   c. Certification Standards.

      (1) Certified. Commandant (G-WK) will certify clinics complying with at least 90% of both key elements and all other elements on the QA Checklist. Clinics must earn re-certification every three years.

      (2) Provisionally Certified. Commandant (G-WK) will provisionally certify clinics complying with at least 80% of key elements and at least 80% of all other elements on the QA Checklist. MLC Health and Safety Divisions will annually re-survey provisionally certified facilities until they attain full certification.

      (3) Not Certified. A facility failing to achieve either certification or provisional certification under this Section's provisions will be subject to a follow-up MLC QA site survey within 180 days after notice of non-certification. During this remedial period, the MLC will assist the facility to promptly address QA survey discrepancies and may impose restrictions

limiting the scope of services the facility can provide. The facility must request a follow-up survey during this period. If the facility does not receive at least provisional certification

(a) MLC will notify the Commanding Officer the health care facility is not certified by letter through the chain of command and detail appropriate specific restrictions on care delivery in that facility.

(b) The Commanding Officer shall submit weekly message reports of progress attained in eliminating disqualifying discrepancies to the cognizant MLC (k), with an information copy to Commandant (G-WKH), through the chain of command.

d. Notice of Certification Status. The Maintenance and Logistics Command will send each surveyed facility a copy of the survey report and recommendations for corrective action within 6 weeks of the site survey. If a facility is not certified, the MLC(k) will send the survey report or an interim action report within two weeks of the site survey. Certified and provisionally certified facilities will receive certificates which they are to display prominently within.

e. Appeal of Certification Status. A Unit Commanding Officer (CO) may appeal the certification status awarded as a result of the MLC Quality Assurance site survey within 30 days of the site survey report date. The Commanding Officer appeals in writing to Commandant (G-WK) through the chain of command; the appeal must specify the particular disputed QA checklist elements and reasons for the appeal. The CO must not base the appeal on corrective actions taken after the QA site survey or local misinterpretation of QA checklist elements or Medical Manual guidelines. Commandant (G-WK) will consider the appeal and render a final verdict on certification status within 30 days of receiving the appeal.

2. Clinic Accreditation Program.

a. All Coast Guard-certified health care facilities with four or more medical officers assigned are expected to pursue accreditation from an external accrediting organization such as the Joint Commission on Accreditation of Health Care Organizations. The cognizant MLC and G-WKH must approve pursuit of this accreditation. Once a clinic achieves full or provisional external accreditation, that facility will automatically receive Coast Guard certification and be required to maintain external accreditation. A non-scored MLC QA survey will also be performed to ensure compliance with Coast Guard regulations and compliance with G-WK quality assurance program standards.

b. The respective Maintenance and Logistics Command will provide any technical and professional assistance the health care facility requires to prepare for external accreditation. On the command's letter request, Commandant G-WK will provide funding for external accreditation surveys through the respective MLC (K).

b. In-service training must include these topics, among others:

(1) Quality Assurance Implementation Guide Exercises;

(2) Annual review of clinic protocols on suicide, sexual assault, and family violence;

(3) Patient satisfaction issues;

(4) Patient sensitivity;

(5) Emergency I.V. therapy;

(6) Pneumatic anti-shock garment (MAST) review;

(7) Emergency airway management;

(8) Cardiac monitor and defibrillator familiarization;

(9) Cervical spine immobilization and patient transport equipment;

(10) Emergency vehicle operator's training (where operated);

(11) Section 13-K infection control policy and procedures.

c. The Chief, Health Services Division, must designate in writing a Health Services Training Coordinator (HSTC) who coordinates clinic in-service training, distributes a quarterly training schedule, and maintains the unit's health services training record. The HSTC's responsibilities include these:

(1) Establishes and maintains a Health Services Training Record to document all training conducted within the clinic. Records should include presentation outline, title, program date, name of presenter, and list of attendees. Maintain training records for 3 years from the date on which training occurred.

(2) Ensures all emergency medical training is documented in the individual's Coast Guard Training Record (CG-5285) for credit toward the 48-hour National Registry EMT continuing education requirement.

(3) Maintains a Training Record section that records personnel certifications including CPR, ACLS, EMT, and flight qualifications, including expiration dates and copies of the current certificate. The HSTC should ensure assigned personnel obtain recertification before current certificates expire.

3. Emergency Medical Training Requirements.

a. All active duty, civilian, and contract civilian personnel working in Coast Guard clinics and sick bays shall maintain current CPR certification at the health care provider level (AHA "C" Course or equivalent).

b. Every Health Services Technician who participates in SAR or MEDEVAC operations must be a currently certified EMT. At least one currently certified EMT will staff Coast Guard emergency vehicles. Unit commanding officers

shall ensure HSs are trained in sufficient numbers under Section 13-M-3.h to meet this requirement.

c. At least one medical officer per clinic will maintain current ACLS certification.

d. Only licensed or certified physicians, nurse practitioners, physician assistants, or Nationally Registered advanced life support providers (EMT-P and EMT-I) will perform ALS procedures, except as Section 13-M-3.e stipulates. Paramedics may perform functions authorized by their certifying jurisdiction's protocols with written medical officer authority.

e. Other than those permitted in the Standardized Health Services Technician Formulary, (COMDTINST 6570.1), an HS in SAR or MEDEVAC situations may provide ALS procedures and medications only if his or her supervising medical officer authorizes such provision in writing and assumes responsibility for those procedures and medications. In emergencies, the supervising medical officer may so authorize by radio.

f. Other than those described in Sections 13-M-3.d and 13-M-3.e, persons who have completed an ACLS course should note certification means only they have completed the course and does not convey a license to perform any skill. Individuals completing ACLS courses shall serve as a clinic resource on current standards for pre-hospital care in training and equipment areas.

g. Emergency vehicles shall be equipped to provide basic life support (BLS) only. The clinic shall maintain equipment (monitor-defibrillator, advanced airway kit etc.) and medications to provide ALS services at in a reserve status and add them when necessary if authorized ALS providers are available.

h. To obtain required EMT training (basic course or recertification), commands shall use local military sources if available. Usually most public service training agencies or community colleges offering training can accept Coast Guard personnel. If the required training is not available from a civilian or military source within a 50-mile radius, commands may use other cost-effective training sources. Submit requests through the chain of command to Commandant (G-WKH) with these items:

   (1) CG-5223, Short-Term Resident Training Request;

   (2) SF-182, Request, Authorization, Agreement and Certification of Training;

   (3) Requests for training outside a 50-mile radius which incur per diem expense require the unit commanding officer's or officer-in-charge's statement local training sources are unavailable.

4. Health Services Technician "A" School.

a. The Office of Personnel and Training operates the 20-week introductory course for Health Services Technicians, including the Emergency Medical Technician (EMT) course, at TRACEN Petaluma. As program manager, Commandant (G-WKH) provides professional comments to the TRACEN on curriculum and qualifying requirements. Commandant (G-PRF) controls HS "A" School personnel quotas. The Training and Education Manual, COMDTINST M1500.1 (series), outlines selection requirements and procedures.

5. Health Services Technician "C" Schools.

   a. Due to the specialized nature of health care, the Coast Guard requires health services technicians to complete training in medical specialty fields such as aviation medicine, preventive medicine, medical and dental equipment repair, physical therapy, eye specialist, laboratory, radiology, pharmacy, and independent-duty specialties. The usual sources are Department of Defense training programs.

   b. Selection for HS "C" Schools is based on qualification code requirements for HS billets at clinics and independent duty sites as specified in personnel allowance lists. Secondary selection criteria include command requests, personnel requests, and deficiencies noted on MLC Quality Assurance Site Surveys.

   c. HS personnel should submit a CG-5223, Short-Term Resident Training Request, with Command endorsement to Commandant (G-WKH) through the appropriate chain of command. Commandant (G-WKH) must receive this request at least 45 days before the training convening date.

   d. HS personnel wishing to pursue "C" school training in courses of 20 weeks or longer require a permanent change of duty station coordinated by Military Personnel Command (CGPC). Submit requests on CG-3698A, Assignment Data Form, to Military Personnel Command (CGPC-emp).

6. Continuing Education Programs.

   a. All U.S. Public Health Service Officers and Coast Guard physician assistants must maintain active professional licenses and/or certification to practice their professional specialty while assigned to the Coast Guard. Licensing and/or recertification requirements often demand continuing professional education, which enhances the practitioner’s skills and professional credentials.

   b. The Office of Health and Safety attempts to fund one continuing education course annually for all licensed health services professionals. The program coordinator for an applicant's professional specialty must approve all training requests. Generally training should provide at least six documentable continuing education credits per day pertinent to the applicant's Coast Guard

billet. Personnel should obtain training at the nearest possible geographic location.

c. Medical and dental officers' licensing and certification exams will not be funded as continuing education. Coast Guard-sponsored Physician Assistant (PA) programs' graduates may request funding for examination fees (primary care only), travel to the testing site nearest their current duty station, and per diem associated with obtaining initial certification from the National Commission on Certification of Physician Assistants. The Coast Guard funds this one-time exception because it sponsors the PA training program and requires certification for employment. PAs may take the recertification examination in conjunction with the annual physician assistant conference. Travel and per diem will be authorized as annual CME. The member pays recertification examination fees.

d. Except for Health Service Technician "C" School applicants, Health and Safety Program personnel requesting continuing education must follow these procedures:

(1) Each person requesting training must complete CG-5223, Short-Term Resident Training Request, with proper endorsements.

(2) Accompany each training request with course literature (e.g., a descriptive brochure) or a brief written description.

(3) Submit SF 182, Request, Authorization, Agreement and Certification of Training (10 parts) with proper endorsements if using a government purchase order to pay tuition or fees.

(4) Send all completed forms to Commandant (G-WKH) for processing. Send one information copy of the Short Term Training Request to the appropriate Maintenance and Logistics Command, Quality Assurance Branch.

(5) Training requests must arrive at Commandant (G-WKH) *8 weeks* before the anticipated training convening date. Coast Guard Training Quota Management Center (TQC), Portsmouth, VA, processes approved requests and issues orders.

7. Long-Term Training Programs.

a. Long-Term Post-graduate Training for Medical Officers (Physicians, Physician Assistants, and Nurse Practitioners). This 1- to 2-year program for medical officers principally emphasizes primary care (family practice, general internal medicine, and pediatrics). Consideration may be given for non-primary care specialties such as occupational health, public health, and preventive medicine. Training in orthopedics is a potential option for mid-level practitioners only. The Health Services Program Manager will consider non-primary care post-graduate medical training only when needed. Applicants also must have applied to their chosen training program and meet

its requirements before requesting training. Applicants should have served with the Coast Guard Health Services Program for at least 2 years for each year of training received. For physician applicants, highest consideration will be given first to those who have not completed an initial medical residency. Commandant (G-WKH) has more information.

b. Advanced Dental Training Programs. This 2-year program provides dental officers advanced training in general dentistry, enabling them to give more effective, comprehensive dental care to Coast Guard beneficiaries. The Department of the Navy, Naval Medical Command, Bethesda, MD, conducts the training, designed to qualify dental officers to meet the American Dental Association and Federal Services Board of General Dentistry requirements for specialty board examination. Dental officers chosen for this program are expected to pursue board certification. For program prerequisites and applications procedures, see the Coast Guard Training and Education Manual, COMDTINST M1500.1 (series).

c. Health Services Administration. This program provides instruction in facility and personnel management, program planning, cost containment, quality assurance, third-party payment and liability, and medical-legal issues. The program provides training at the undergraduate (bachelor's degree) level for Chief Warrant Officers and senior enlisted HS personnel (Medical Administrators) and post-graduate (master's degree) level for officers in grades O-2, O-3, and O-4. See the Coast Guard Training and Education Manual, COMDTINST M1500.1 (series) for eligibility requirements, prerequisites, and application procedures.

d. Physician Assistant Program. Conducted at the U.S. Intra-service Physician Assistant Program, Fort Sam Houston TX, this program trains Coast Guard personnel interested in becoming Physician Assistants. Program graduates receive a baccalaureate degree from the University of Nebraska. If they meet eligibility requirements, graduates are offered a direct commissions as ensigns as described in the Personnel Manual, COMDTINST M1000.6 (series), Article 1.A.7. Each year three Coast Guard students are selected for training based on Service needs. Training at other institutions is not authorized. See the Coast Guard Training and Education Manual, COMDTINST M1500.1 (series) for eligibility requirements, prerequisites, and application procedures.

Section N - Patient Affairs Program

1. Patient Sensitivity.

   a. The Coast Guard considers patient sensitivity issues of paramount importance in delivering health care. Important issues in this area include medical record confidentiality, privacy during medical examination and treatment, respect for patient concerns, and enhancing the patient's perception of the quality of services delivered.

   b. All clinics shall conduct continuing patient sensitivity training. The "Treat Everyone As Myself" (TEAM) Program, developed by the U.S. Navy and Service Quality Institute available through each MLC Health and Safety Division, is the recommended course. It provides the structure for an internal review of patient-provider interaction and suggestions on ways to improve this relationship.

2. Patient Advisory Committee (PAC).

   a. The Coast Guard's health services program provides primary health care to a wide array of beneficiaries authorized by law and regulation. Medical Treatment Facilities (MTFs) often are unaware of their population's health problems until patients voice complaints or criticisms to the command. To enable beneficiaries to express their concerns, a PAC must be available to open lines of communication between health care providers and care recipients.

   b. Each Coast Guard MTF shall establish a PAC and specify criteria for committee functions. PACs shall include one officer and one enlisted member not assigned to the clinic; an active duty representative from each Coast Guard command in the clinic's service area; an active duty representative from each of the other uniformed services using the MTF; a retired representative; and an active duty dependent representative from both officer and enlisted communities.

   c. MTF shall conduct PAC meetings at least quarterly.

   d. The Chief, Health Services Division or his or her designee shall chair the meeting. Meeting minutes shall include recommended actions and an attendance list; and will be forwarded to the commanding officer with a copy to each PAC member. Specific PAC objectives include:

      (1) Advise the Chief, Health Services Division on the range of services the beneficiary population requires;

      (2) Serve as a communications link between the MTF and the beneficiaries the members represent;

(3) Serve as a patient advocacy group to assure all patients are accorded their rights as described in the Commandant's Patient Bill of Rights and Responsibilities;

(4) Assist the Chief, Health Services Division in advising patients of their responsibilities as described in the Commandant's Patient Bill of Rights and Responsibilities;

(5) Assist the Chief, Health Services Division in establishing patient education programs; and

(6) Advise the Chief, Health Services Division on the acceptability and convenience of the services provided.

3. Patient Satisfaction Assessment.

a. Assessing patient satisfaction through patient satisfaction surveys has become an effective, efficient method to investigate and measure the quality of the Coast Guard health care delivery system from the patient's perspective.

b. A patient satisfaction survey form shall be available to every patient who receives care at a Coast Guard facility.

c. Satisfaction surveys will be conducted annually for all patient visits during a randomly selected one-week period.

d. Locally prepared patient satisfaction surveys are authorized for use.

e. Patient satisfaction survey results shall be provided to the quality assurance focus group for discussion and action and documented in meeting minutes. Survey results shall report and recommended actions to the unit commanding officer.

f. Persons distant from a Coast Guard clinic can comment about care received from civilian providers by sending a mail-in Maintenance and Logistics Command survey form available from unit Health Services Technicians.

4. Patient Grievance Protocol.

a. The Coast Guard expects health services personnel to maintain a professional attitude at all times. Our goal to provide the highest quality health care within allotted resources to all beneficiaries with the least personal inconvenience. Despite our best efforts, occasionally a patient will be dissatisfied with the care received.

b. Whenever possible individuals with grievances should seek out or be referred to the clinic supervisor, health benefits advisor (HBA), or clinic administrator (CA) for complaint resolution before leaving the clinic. Refer written or telephone complaints to the appropriate clinic staff member. At a minimum, the complainant shall be given the name of his or her unit Patient Advisory

Committee representative and advise the complainant of the time and place of the next PAC meeting.

c. If the clinic supervisor, HBA, or CA cannot resolve the complaint, he or she shall refer the complainant to the senior medical or dental officer as appropriate.

d. Refer the complainant to the commanding officer or higher authority only if the patient believes the clinic or PAC has not resolved the complaint.

e. MLC (kqa) shall review concerns reported on forms mailed to the Maintenance and Logistics Command for quality assurance purposes, action, or referral to an appropriate level for resolution and follow up.

5. Congressional Inquiries.

a. Occasionally, circumstances arise in which beneficiaries exercise their right to solicit assistance from their elected Congressional Representative to resolve their complaint with the Coast Guard health care system.

b. The Coast Guard maintains a Congressional liaison staff to direct inquiries to the appropriate Headquarters office that can best address the issue and respond satisfactorily. Normally Commandant (G-WK) replies to health care problems.

c. Congressional inquiries require a complete investigation of the circumstances surrounding the issues the beneficiary addresses. To this end, the command, health care facility, and individuals involved must supply supporting documentation and/or statements to assist in the investigation.

6. Patient Bill of Rights and Responsibilities. Each Coast Guard health care facility shall conspicuously display the Commandant's "Patient Bill of Rights and Responsibilities."